MAP-20-C

DEPARTMENT FOR MEDICAID SERVICES
Pharmacy Claim Form

Mail completed form to: Unisys
P. O. Box 2105
Frankfort, KY 40602-2015

PHARMACY NAME AND ADDRESS

1 Provider Number	2 Group Number	3 Day Filled	4 Customer Location

5 Medical Assistance ID Number	6A Recipient's Name	6B
	First	Last

1

7 Day Rx Written	8 Refill	9 NDC Number	10 Quantity	11 Days Supply
12 Prescription Number	13 Prescriber's License Number	14 Brand Necessary	15 Patient Counseling	16 Unit Dose Indicator
17 Prior Authorization Number	18 Compound Code	19 Pregnancy Indicator	20 Local Use Only	21 Diagnosis Code
22 Amount From Other Source	23 Patient Paid Amount	24 Total Charge		

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This is to certify that the foregoing information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the Department for Medicaid Services. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws and may result in termination from the Program.

25 Invoice Date	26 Invoice Number

Provider Signature _____